

additional studies are needed to better understand these results.

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Overnight unattended home hemodialysis

To the Editor: Precedent claims are rarely correct, thus, the statement by Dr. McFarlane, Dr. Pierratos, and Dr. Redelmeier in a recent issue of *Kidney International* that they invented unattended self home overnight hemodialysis in Toronto in 1993 [1] cannot go unchallenged. I believe that my group and I were the first to develop this technique 30 years earlier and that we published extensively in the period 1963 to 1968 on this subject [2–6]. In addition, visual proof of my claim can be seen in a video of self-unattended overnight home hemodialysis in 1968 by any of your readers at www.mybesthealth.com/shaldon/wmv/cahmed.wmv [7].

However, the authors are to be congratulated on their excellent emphasis on the cost effectiveness of this type of dialysis, which was the main goal of our development of the technique in a cash-starved National Health Service in the United Kingdom.

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Reply from the Authors

We would like to thank Dr. Shaldon for his letter and his complimentary words on our work. Dr. Shaldon's pioneering work in the area of home dialysis is well known, undisputed, and remarkable, especially taking into account the technical limitations of the time [1]. We never disputed the fact that home hemodialysis has been done before at night, or that both long dialysis [2], as well as daily dialysis [3] were well established regimens. Our contribution is the successful combination of these three elements. To our knowledge from the review of the literature, Dr. Shaldon's home nightly dialysis was performed three and rarely four times a week. We believe that the combination of all three elements—high frequency, long duration, and the location at home is responsible for the success of our regimen, as has recently been pointed out by Kooistra [4].

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Influence of dialysis membranes on outcomes in acute renal failure

To the Editor: In their recent meta-analysis published in *Kidney International*, Subramanian, Venkataraman, and Kellum [1] used a fixed effects model to combine the results of the studies addressing the impact of synthetic dialysis membranes on survival in acute renal failure. In addition, their primary analysis pooled results from an observational study with those from randomized/quasi-randomized trials. In our opinion both of these approaches are inappropriate.

Fixed effects models assume that the effect of treatment